

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5641 CERTIFICATE OF DEATH

Reg. Dist. No.

05635

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pennington St.		d. STREET ADDRESS Pennington St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jesse	Middle James	Last Ashby
4. DATE OF DEATH	Month May	Day 11,	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 29, 1890
9. AGE (In years from birthday) 69 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerical Worker, Offices	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ralph T. Ashby	14. MOTHER'S MAIDEN NAME Rachel Shaffer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO. 219-34-6365	17. INFORMANT Mrs. Myrtle Ashby	Address Oakland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Coronary Occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/12/59</u> , 19 <u>to</u> <u>5/11/59</u> , 19, that I last saw the deceased alive on <u>6/12/59</u> , 19, and that death occurred at <u>9:30A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. I. Baumgartner, M. D.</u>		ADDRESS (Street, city or town, state) 25 Alden St Oakland, Md.	
22a. BURIAL, CREMATION, CREMATOR (Specify) Burial		22b. DATE THEREOF 5/13/1959	22c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery
22d. LOCATION (City, town, or county) Oakland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. Requichet</u>		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE MAY 18 '59
		24b. REGISTRAR'S SIGNATURE <u>Arthur & Kraus</u>	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5642

CERTIFICATE OF DEATH

Reg. Dist. No.

05636

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md		c. LENGTH OF STAY IN 1b 40 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GLENN		First SCOTT	Middle Last COLLIER			
4. DATE OF DEATH	Month May	Day 14	Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1907			
9. AGE (In years less birthday) 52 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. KIND OF BUSINESS OR INDUSTRY Own farm	12. BIRTHPLACE (State or foreign country) Harnedsville, Pa.			
13. FATHER'S NAME Tarleton Collier	14. MOTHER'S MAIDEN NAME Ella Leslie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 101-10-7528	17. INFORMANT Mrs. Hazel Collier, Accident, Md.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction						
420.1 DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)						
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) May	(County) Addison	(State) Pa.
21. I certify that I attended the deceased from Sept 17, 1958, to May 14, 1959, and that death occurred at 10 a.m. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	DATE SIGNED R.D. MARKLESBURG, Pa. May 15	
ACTUAL SIGNATURE Harold O. Kamons		PHYSICIAN'S NAME (Type) HAROLD O. KAMONS		R.D. MARKLESBURG, Pa.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/59	22c. NAME OF CEMETERY OR CREMATORIAL Addison	22d. LOCATION (City, town, or county) Addison	(State) Somerset Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman		ADDRESS Grantsville, Md.	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	DATE MAY 18 '59 Arthur S. Hause	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5643

05637

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton R.F.D.		c. LENGTH OF STAY IN 1b		b. COUNTY Garrett					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barton Rural						
3. NAME OF DECEASED (Type or print) MAGGIE			First MAGGIE	Middle CUSTER	Last CUSTER				
4. DATE OF DEATH 5/22/1959	Month 5	Day 22	Year 1959						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb, 20th. 1867	9. AGE (in years at birthday) 92	10. IF UNDER 1YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) New. Germany, Garrett Co. U.S.A.			
13. FATHER'S NAME Joseph Warnick			14. MOTHER'S MAIDEN NAME Mary Mc Intyre			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None			17. INFORMANT Elsie Custer, Barton, Md. (Rural)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Anteriosclerosis (Arterio - Renal Disease)						INTERVAL BETWEEN ONSET AND DEATH Transient			
DUE TO (b)						DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Garrett County (Rural)	(County) Garrett County	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<p>ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i></p> <p>EXAMINER'S NAME (Type) <i>James H. Feaster, Jr.</i></p> <p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED <i>5-22-59</i></p>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/1959		22c. NAME OF CEMETERY OR CREMATORIAL New Germany Cemetery		22d. LOCATION (City, town, or county) Garrett County (Rural)		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN			ADDRESS LONACONING, MD.			24a. REC'D BY REGISTRAR Critting & Sons	24b. REGISTRAR'S SIGNATURE Critting & Sons		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5644 CERTIFICATE OF DEATH

Reg. Dist. No. 05638

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		d. STREET ADDRESS Kolberg Hill	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Christina	Middle Whitefield	Last Evans
4. DATE OF DEATH	Month May	Day 8,	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work, for self and others		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland.	9. AGE (In years last birthday) 55 yrs.
13. FATHER'S NAME Cam Whitefield		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Chas. W. Butts	Address Gormanian, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Acute Myocardial Infarction			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cerebral Hemorrhage with rt. sided (c) Paralysis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Phlebitis (right)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1957</u> to <u>May 8, 1957</u> that I last saw the deceased alive on <u>May 8, 1957</u> , and that death occurred at <u>10:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Ralph Calandrella</i>	M.D.	<i>Kitzmillerville, Md.</i> May 13-59	
PHYSICIAN'S NAME (Type) Ralph Calandrella, M. D.			
220. BURIAL, CREMATION, REMOVAL (Specify) Burial 5/12/1959	22b. DATE THEREOF 5/12/1959	22c. NAME OF CEMETERY OR CREMATORIUM Philo Cemetery	22d. LOCATION (City, town, or county) Westernport, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i>	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE MAY 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

THE STATE OF GEORGIA - BIRMINGHAM 18

CERTIFICATE OF DEATH

DEATH

John Smith, deceased, died on the 1st day of January, 1999, at the age of 75 years, 1 month, 15 days, in the city of Birmingham, State of Georgia, from natural causes.

John Smith, deceased, died on the 1st day of January, 1999, at the age of 75 years, 1 month, 15 days, in the city of Birmingham, State of Georgia, from natural causes.

DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5645 CERTIFICATE OF DEATH

Reg. Dist. No. 05639

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Grant				
c. LENGTH OF STAY IN lb 20 Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gormanian 85 x 3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) Vernie		First Middle Catherine	4. DATE OF DEATH Month May Day 15 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1897	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME Newton Lloyd		14. MOTHER'S MAIDEN NAME Alberta Whistler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 228-28-6741		17. INFORMANT "Husband" Roy R. Hanlin		Address Gormanian, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260 X		DUE TO Diabetes Coma		INTERVAL BETWEEN ONSET AND DEATH 12 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Diabetes Mellitis				10 years		
		(c) Arteriosclerosis		10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland (County) Maryland (State) W. Va.
21. I certify that I attended the deceased from 5-15- 19 59 to 5-15-59 19 59 that I last saw the deceased alive on 5-15-59 19 59 , and that death occurred at 7:20 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Oakland, Maryland DATE SIGNED 15 May 59		
ACTUAL SIGNATURE <i>Andrew E. Mance</i>		M.D.				
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/59		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem.		22d. LOCATION (City, town, or county) Thomas, W. Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Deacon</i>		ADDRESS Thomas, W. Va.		24a. REC'D BY REGISTRAR DATE MAY 18 '59		
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

87, FROM ITAS-117249H 90 7851N 11749E STAT2 DHA 115AM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5646 CERTIFICATE OF DEATH

05640

Reg. Dist. No.

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH o. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller		c. LENGTH OF STAY IN 1b 30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kitzmiller		d. STREET ADDRESS / State St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION State St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Adrian	Last Metz	4. DATE OF DEATH May 23 1959	Month May	Day 23	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1983	9. AGE (In years lost/birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Metz				14. MOTHER'S MAIDEN NAME Adeline Kerns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT Mrs. Ella Metz-Kitzmiller, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 3 days 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cerebral Hemorrhage with its complications</i> 1 week DUE TO (c) <i>Hypertension</i> 2 yrs DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Schizophrenia</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 23</i> , 1959, to <i>May 23</i> , 1959, that I last saw the deceased alive on <i>May 23</i> , 1959, and that death occurred at <i>7:00 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <i>Kitzmiller, Md.</i> DATE SIGNED <i>May 23-59</i>							
ACTUAL SIGNATURE <i>Ralph Cahandella</i>		PHYSICIAN'S NAME (Type) <i>Ralph Cahandella</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/59		22c. NAME OF CEMETERY OR CREMATORIAL Philos		22d. LOCATION (City, town, or county) Westernport (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>El. Baval</i>				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5647 CERTIFICATE OF DEATH

Reg. Dist. No. 05641

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		b. COUNTY Garrett		
c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kitzmiller		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Michaels	
4. DATE OF DEATH	Month May	Day 8	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1959	
9. AGE (In years lost birthday) yrs. 1 1/2	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	11. BIRTHPLACE (State or foreign country) Oakland, Maryland	12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Richard Michaels	14. MOTHER'S MAIDEN NAME Helen Louise Paugh	Address Mrs. John R. Michaels, Kitzmiller, Maryland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---	16. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs. John R. Michaels, Kitzmiller, Maryland	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Heart Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Atelectasis.	INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 7, 1959, to May 8, 1959, that I last saw the deceased alive on May 8, 1959, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. James H. Feaster, Jr.				ADDRESS (Street, city or town, state) M.D. 58-1-14 Oakland, Md. 20702-311XV2
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/9/1959	22c. NAME OF CEMETERY OR CREMATORIUM Tasker Cemetery	22d. LOCATION (City, town, or county) near Vindex, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leedlestone	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE MAY 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF NEVADA
DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE OF DATA

DATA NO. 100-1000

DATA NO. 100-1000

DATA NO. 100-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

564 CERTIFICATE OF DEATH

Reg. Dist. No. **05642**

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 1 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard	
3. NAME OF DECEASED (Type or print) Laura Miller Rager		d. STREET ADDRESS ---	
4. DATE OF DEATH May 6, 1959	Month May	Day 6	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1871
9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Evans		14. MOTHER'S MAIDEN NAME not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs. C. W. Schaeffer	Address Gormanian, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Milk Thistle - Vitamin D deficiency 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month May Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1958 to May 1959 , that I last saw the deceased alive on May 4 1959 , and that death occurred at 9:15P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. I. Baumgartner</i>	ADDRESS (Street, city or town, state) 25 Alder St		DATE SIGNED 5/8/59
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D.	22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/9/1959 22c. NAME OF CEMETERY OR CREMATORIUM Bayard Cemetery 22d. LOCATION (City, town, or county) Bayard, W. Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Reighton</i>	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE MAY 18 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MANUAL OF STATE DRAFTING
CHARTS OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05643

564 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Garrett		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	
3. NAME OF DECEASED (Type or print)		First Clarence	Middle Edward
		Last Sharps	4. DATE OF DEATH 5
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME Lewis Allen Sharps		14. MOTHER'S MAIDEN NAME Anna Squires	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 171-47-8398	17. INFORMANT John Sharps
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Address Third St. Oakland, Md.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) Arteriosclerosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diseases		INTERVAL BETWEEN ONSET AND DEATH 7 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diseases	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-8, 1952, to 4-8, 1952, that I last saw the deceased alive on 4-8, 1952, and that death occurred at 10-8 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE JAMES H. DENTON, M.D. 582-134 OAKLAND MD 51559			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/15/1959	22c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		ADDRESS Oakland, Maryland	24a. REC'D BY REGISTRAR DATE MAY 18 '59
			24b. REGISTRAR'S SIGNATURE Arthur & Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05644

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Rural		c. LENGTH OF STAY IN lb 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Thayers Motel, Route #219		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Regina	Middle Elizabeth	Last Thayer
4. DATE OF DEATH	Month May	Day 6,	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 15, 1918
9. AGE (In years last birthday) 40 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Maryland.
13. FATHER'S NAME James Compton	14. MOTHER'S MAIDEN NAME Bertha Miller	15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 214-34-2051		17. INFORMANT Phillips Thayer R. D. Oakland, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0		Acute Hepatic failure secondary to fatty degeneration of the liver	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral edema	
DUE TO (b)		18 hrs.	
DUE TO (c)		18 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		DATE SIGNED 5-7-59	
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/1959	
22c. NAME OF CEMETERY OR CEMINATORY Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leggerton</i>		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE MAY 18 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Trahan</i>	

STATE OF NEW YORK - DEPARTMENT OF HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

325

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05645**

1. PLACE OF DEATH a. COUNTY Garrett County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 23 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Route Oakland, Maryland	
						d. STREET ADDRESS /	
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julie		First Julie Middle Ann		Last Whitmer		4. DATE OF DEATH May 29 1959	Month Day Year
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 5/11/1873		9. AGE (In years last birthday) 86 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Moyer				14. MOTHER'S MAIDEN NAME Katherine Hatterman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Joseph Smith		Address Star Route, Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Acute Heart Failure					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary Occlusion					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Fracture head left femur - Hydro Thorax							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell May 6					
20c. TIME OF INJURY Hour o. m. 2 p. m.		Month, Day, Year May 6 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
						20f. (City or town) Near Oakland Garrett, Md.	
						(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. I. Baumgartner</i>						DATE SIGNED May 30, 1959	
EXAMINER'S NAME (Type) Dr. E. I. Baumgartner				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/1959		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		22d. LOCATION (City, town, or county) near Gorman, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Neighron</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JUN 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

MEDICAL DISEASES CERTIFICATE OF DEATH

2822

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